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ABSTRACT

This leaflet examines alcohol and other drug abuse prevention for individuals with traumatic brain injury. The characteristics and incidence of traumatic brain injury (TBI) are noted. The implications of alcohol and other drug use are discussed, emphasizing that TBI is often related to lifestyles where alcohol and other drug abuse and risk taking are common, and that if alcohol or other drug use predates the disability, the problems will likely continue following rehabilitation. The guide includes points to stress in discussing the effects of drug use with a person with TBI. Suggestions are offered to bring about positive interactions, and six myths commonly held about TBI are dispelled with factual information. Five organizational resources and five printed resources are listed as sources of more information. (JDD)

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A Look at Alcohol and Other Drug Abuse Prevention and...

TRAUMATIC BRAIN INJURY

Traumatic brain injury refers to damage to the brain caused by external mechanical forces applied to the head. The traumatic brain injury (TBI) is acquired suddenly in the course of normal development. It typically results in brain damage which is diffuse or widespread; it is not usually confined to one area of the brain. Thus, impairments are multiple and many aspects of life are changed.

Someone receives a traumatic brain injury every 15 seconds in the United States. Over 2 million injuries occur per year with 500,000 severe enough to require hospital admission. Between 75,000 and 100,000 people die each year from a traumatic brain injury, which is also the leading killer and cause for disability in children and young adults. The economic costs alone approach $25 billion per year, and astronomical medical and legal bills often leave families in financial ruin.

Among those who survive, 90,000 people will be severely and permanently disabled. They will experience deficits in physical, psychosocial, intellectual, cognitive, vocational, educational, recreational, and independent living skills. These deficits will vary in intensity over time, and will interact in ways unpredictable and unique. These interactions require extremely complex management and rehabilitation methods.

FOR YOUR REFERENCE

DESCRIPTORS OFTEN USED FOR TBI INCLUDE:

Acquired Brain Injury
Brain Injury
Head Injury

The Implications of Alcohol and Other Drug Use

Alcohol abuse has been associated with TBI in over half of all occurrences. It appears to be related in many cases with lifestyles where alcohol and other drug abuse and risk taking are common (Sparadeo, et al., 1990). If the disability is a direct result of alcohol or other drug use, or if it predates the disability, the chances are greater that the problems will continue following rehabilitation. The continued abuse of alcohol and other drugs can negate attempts at physical, social, and cognitive rehabilitation.

Specialized alcohol and other drug abuse treatment often is necessary for people with traumatic brain injury. TBI's can include lasting memory and cognitive difficulties, and alcohol and other drug abuse treatment needs should be addressed by taking learning styles and capacities into consideration. Medical care for TBI is costly, and it is not uncommon to exhaust financial resources before the person can access appropriate alcohol and other drug abuse treatment.

Alcohol and other drug abuse prevention might best be approached by emphasizing the effects of alcohol and other drug use upon the damaged brain and a person's recovery from TBI. For example, the following points might be emphasized in the discussion with a person with TBI:

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- The disinhibiting effects of alcohol are not helpful when disinhibition itself is a social problem for many persons with TBI.
- The depressant effects of alcohol and many other drugs are not helpful when proneness to major reactive depressive episodes are so common among person recovering from TBI.
- The effects of alcohol and other drugs may interfere with medications designed to prevent seizure episodes. They also may lower the seizure threshold.
- It is highly undesirable to exacerbate deficits in planning, verbal fluency, motor control, concentration, attention, memory, and information procession speed, which are already problems in recovering from TBI.

Resources: To explore the issues related to alcohol and other drug dependency treatment, obtain a copy of the *Substance Abuse Task Force White Paper.* Reprints of the White Paper are available from the National Head Injury Foundation, 1140 Connecticut Avenue, NW, Suite 812, Washington, DC 20036, (202) 485-9950.

Alcohol, Drugs, and Brain Injury, a survivor's workbook, by Robert Karol, Ph.D. and Frank Sparadeo, Ph.D., 1991. Copies of this workbook are available free of charge by calling 1 (800) CARE TBI x3074.

Suggestions to Improve Positive Interactions

People with TBI may digress or change course during a conversation. Redirect them using appropriate cues and reinforcers.

Teach prevention skills to the person with TBI in more than one setting to maximize generalization. Focus on a specific prevention goal.

Be redundant. Never assume understanding or memory from a previous session. Always repeat the purpose, duration, and guidelines for each meeting. Summarize previous progress and then restate where the previous meeting left off.

It must be understood that because the consequences of TBI are so psychologically overwhelming, most persons experience pervasive denial. This is perfectly normal. The timing and method of confrontation about deficits, including alcohol and other drug problems, should be carefully coordinated with the interdisciplinary TBI treatment team and case manager.

Present educational points in the most effective cognitive and sensory mode. This information is best obtained from a TBI team member known as the Cognitive Specialist.

All interventions should be directive in nature, short term, goal directed, and behaviorally anchored.

Severe brain injuries are typically so devastating to the family system that many family members "leave the field" when they come to appreciate what has occurred. Social isolation is common for people with TBI. The family system must be assessed and reassessed as it will fluctuate markedly in the first four years following TBI.

Accentuate positive gains using frequent social praise.

MYTHS & **FACTS**

MYTH: *Most people with a very severe TBI will likely die.*

FACT: Because of advances over the last two decades in emergency room medicine, neurosurgical techniques, and pharmacological agents, the survival rate for people with severe TBI has quadrupled to nearly 60%. Most are young adult males who will live a full lifespan.

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MYTH: *Brain damage is permanent and irreversible. Life after TBI is not worth living.*

FACT: There is a period of spontaneous neurological recovery of about two years in which significant improvements occur. These can be sometimes augmented by extensive and expensive rehabilitation methods. Some people with severe TBI will eventually live independently and work competitively with supports, but rarely at the level of functioning they enjoyed prior to injury.

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MYTH: *People with TBI are volatile, aggressive, and unpredictable.*

FACT: Almost all people who have experienced severe TBI pass through a phase of agitation during their recovery. This is normal and must not be confused with a permanent psychiatric condition. Behavioral problems that do linger for a minority of persons with TBI will likely include confusion, disinhibition, and/or reservation as opposed to aggression.

MYTH: *People with TBI experience dramatic losses of intellectual functioning.*

FACT: There is usually some loss of intellectual functioning, but this can be confused with more specific cognitive deficits such as problems in attention/concentration, short-term memory, or the speed of information processing. These are often the most significant impediments to long-term recovery.

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MYTH: *Most TBI's occur among people who were drinking and driving.*

FACT: About two-thirds of TBI's involve motor vehicle accidents. Half of the accidents which resulted in TBI are alcohol-related. Even in these circumstances, the people incurring TBI were often passengers or not intoxicated themselves. Falls, work-related accidents, sports-related injuries, and firearms account for many head injuries.

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MYTH: *The point of impact and force of a TBI tells us a great deal about its consequences.*

FACT: Most brain injuries are diffuse (affecting the whole brain and brain stem) and are not localized. The combinations and permutations of damage to over 10 billion interdependent nerve fibers are almost infinite, as are the manifestations of TBI.

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For More INFORMATION

Organizations

National Head Injury Foundation (NHIF)
1140 Connecticut Avenue NW, Suite 812
Washington, DC 20036
(202) 296-6443
(800) 444-NHIF (Family Help Line)

JMA Foundation
1730 M Street NW, Suite 903
Washington, DC 20036
(800) 447-8445

Community Contacts

NHIF has chapters in many states.

To locate additional resources contact your state Governor's Committee of People with Disabilities

or obtain a State Resource Sheet from

National Information Center for Children and Youth with Disabilities
PO Box 1492
Washington, DC 20013
(703) 893-6061
(800) 999-5599
(703) 893-8614 TDD

Government Agency

National Institute of Neurological Disorders and Stroke
Building 31, Room 8A06
9000 Rockville Pike
Bethesda, MD 20892
(301) 496-5924

References

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Langley, M.J. (1991). Preventing post-injury alcohol-related problems: A behavioral approach. In B.T. McMahon and L.R. Shaw (Eds.), *Work Worth Doing: Advances in Brain Injury Rehabilitation*, Orlando: Paul M. Deutsch Press, Inc.

Sparadeo, F.R., Strauss, D., and Barth, J.T. (1990). The incidence, impact, and treatment of substance abuse in head trauma rehabilitation. *Journal of Head Trauma Rehabilitation*, 5(3), 1-8.

This information was developed as a part of a set of materials on alcohol and other drug abuse prevention and disability. Other documents on specific topics are available upon request.
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